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A Doctor's Duty to Disclose Life Expectancy Information to Terminally Ill Patients

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A DOCTOR'S DUTY TO DISCLOSE LIFE EXPECTANCY INFORMATION TO TERMINALLY ILL PATIENTS

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I. INTRODUCTION

"Questions of right and wrong are as old as medicine itself. . . ."¹ Care for the terminally ill is certainly one of the most emotionally charged responsibilities one might face during his lifetime. Whether an individual chooses medicine as his occupation or is exposed to medicine (or medical care for the terminally ill) within his personal life, care for the terminally ill can certainly take a toll on one's psyche. Some people feel that caring for a person whose life is nearing an end is a privilege and a gift.²

Perhaps nothing is more devastating than the decision about whether to tell a patient he has cancer.³ The manner in which one makes disclosures is critical for the patient and may determine his emotional status and capacity to function from that point forward.⁴ However, some people advocate withholding disclosures from the terminally ill.⁵ Concealment of diagnoses and prognoses occur in cases other than those concerning terminal illness; however, such actions seem to occur most often in cases in which doctors diagnose the patient with cancer.⁶ Although some argue for the so-called "therapeutic privilege," this author proposes that this privilege should be construed very narrowly and used only in the rarest of cases.

At one time, the physician's word was akin to that of God.⁷ "The doctor said" was pronounced with almost religious conviction.⁸ Doctors did what they believed best, and people generally accepted those decisions.⁹ However, this belief has recently begun to change due to a new focus on patient autonomy.

¹Laura Taxel, *Brave New World: Exploring the Relationship Between Medicine and Morals*, CLEVELAND PLAIN DEALER SUNDAY MAGAZINE, Jan. 9, 1994, at 8.

²Dallas M. High, *Truth Telling, Confidentiality, and the Dying Patient: New Dilemmas for the Nurse*, 24 NURSING FORUM 5, 10 (1989).

³Donald Oken, *What to Tell Cancer Patients: A Study of Medical Attitudes*, 175 JAMA 1120 (1961). Patients have varying reactions to learning that they have a disease that may or may not be curable. For some people, nothing is more frightening than hearing the word cancer associated with either themselves or a loved one. Knowledge of such information brings out expressions of anger, depression, denial or any combination of such emotions. *Id.* at 1126. Questions arise regarding the capacity of human beings to adapt to the expectation of death. *Id.* at 1125. Some people are driven to fight while others see the situation as hopeless and give up.

⁴Oken, *supra* note 3, at 1125.

⁵Notes, *Informed Consent and the Dying Patient*, 83 YALE L.J. 1632, 1653 (1974) (hereinafter Notes).

⁶Benjamin Freedman, *Offering Truth: One Ethical Approach to the Uninformed Cancer Patient*, 153 ARCHIVES INTERNAL MED. 572 (1993).

⁷See Taxel, *supra* note 1, at 17.

⁸*Id.*

⁹*Id.*

"'Let's face it,' says [Dr. Stuart] Younger,¹⁰ 'Until recently, most physicians have been white, Protestant males. They did what they thought was best, but what they thought did not include the traditions, morals and viewpoints of everyone else.'"¹¹

As early as 1891, the Supreme Court noted that "no right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."¹² "One of the most neglected aspects of the physician-patient relationship is the right of the patient to be a self-sovereign, autonomous, free human being."¹³ When an individual concludes that it is in the "best interest" of the patient for the physician to lie to that patient, then individual has decided that the physician, not the patient, is the authority on the "best interest" of the patient.¹⁴ This directly contradicts the premise of autonomous decision-making by the patient.¹⁵

Health care professionals are sometimes reluctant to disclose diagnoses and prognoses to dying patients.¹⁶ "Such protectionism has created what was known in the '60s and '70s as an environment of "a conspiracy of silence" directed toward the terminally ill."¹⁷ This attitude is not the best situation for the terminally ill in today's society.¹⁸ For most dying persons, hope centers around the quality of remaining life and a general assessment of life's values.¹⁹ "It is the care provider's moral duty to allow patients to live out their lives as individuals until they die."²⁰ A person cannot live their life as they wish if they are not aware of all the facts pertaining to their bodily condition.

¹⁰Dr. Stuart Younger is co-director of the Clinical Ethics Program at University Hospital of Cleveland and a member of the task force to revise The Encyclopedia of Bioethics. The encyclopedia serves as guidance when facing moral questions pertaining to such things as religious objections to medical care, abortion, AIDS, assisted suicide and fertility measures. The five-volume edition will define the moral dimensions of modern science, medicine and health care for the 21st century. *Id.*

¹¹*Id.* at 17 (citing Dr. Stuart Younger).

¹²*Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

¹³David Morris, *Truth Telling in Medicine*, 247 JAMA 2659 (1982).

¹⁴*Id.* "Harm is inflicted upon the patient by undermining his right of self-determination when information is withheld." Alan Meisel, *The "Exceptions" To The Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WISC. L.REV. 413, 469.

¹⁵See Morris, *supra* note 13, at 2659.

¹⁶See High, *supra* note 2, at 6.

¹⁷*Id.*

¹⁸*Id.*

¹⁹*Id.*

²⁰*Id.* at 9.

As patients demand their right to information, evidence suggests that disclosure is beneficial.²¹ "It is naive to assume that professionals and family members can successfully conceal awareness of terminal illness from a patient."²²

It is the purpose of this Note to review and evaluate the benefits to making full disclosure to a terminally ill patient. It is this author's position that a patient's well-being and dignity dictate that the physician be forthright with all information regarding a patient's diagnosis and the range of treatments available, including both active and passive treatments.

II. A DOCTOR'S GENERAL DUTY TO DISCLOSE

A. History and Theory of Informed Consent

Truth telling is essential to informed consent.²³ The legal doctrine of informed consent requires disclosure of information that is material to a treatment decision before seeking the patient's consent.²⁴ Growing concern over the compound issue of "full disclosure" has provoked much debate among health care and legal professionals.²⁵ Courts developed the informed consent doctrine to promote the patient's well-being and to protect the patient's right to self-determination.²⁶

Respect for autonomy is the most frequently mentioned principle behind the doctrine of informed consent.²⁷ Many terms such as "privacy," "voluntary," "freedom to choose" and "self-mastery" are commonly associated with the phrase "respect for autonomy."²⁸ The doctrine of informed consent acknowledges that each person is the master of his or her own body, and that the patient should make the final treatment decision.²⁹ The doctrine instructs that competent patients determine what treatment is acceptable to them after

²¹See High, *supra* note 2, at 6.

²²*Id.*

²³Edmund Pellegrino, *Is Truth Telling to the Patient a Cultural Artifact?*, 268 JAMA 1734 (1992).

²⁴Hilda Slive, *Informed Consent*, 249 JAMA 815 (1983).

²⁵Dennis H. Novack, et al., *Physicians' Attitudes Toward Using Deception to Resolve Difficult Ethical Problems*, 261 JAMA 2980 (1989). See also Oken, *supra* note 3, at 1125.

²⁶G. ANNAS, *THE RIGHTS OF HOSPITAL PATIENTS*, 59 (1975) (noting the modern trend as viewing the relationship between doctor and patient as a partnership in making decisions rather than as a monopoly by medical personnel).

²⁷RUTH R. FADEN & TOM L. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* 7 (1986).

²⁸*Id.*

²⁹Conny D. Beatty, *Comments, Case of No Consent: The DNR Order as a Medical Decision*, 31 ST. LOUIS U. L.J. 699, 700 (1987).

being informed of the risks and benefits of the treatment offered and the alternatives that are available.³⁰

1. Elements of Informed Consent

The doctrine of informed consent includes four essential components.³¹ First, there must be full disclosure of the risks and benefits of the proposed treatment and the available alternatives.³² Second, the information should be provided in an easily comprehensible form.³³ The third component requires that the consent be obtained freely and without coercion³⁴ or undue influence.³⁵ Finally, the patient must be competent to give his or her consent.³⁶ In essence, informed consent consists of the doctor communicating important information to his patient and the patient consenting to the treatment.

Consent ranks as the most obvious element to "informed consent." Essentially, consent is an individual's decision to authorize a doctor to perform a particular medical intervention.³⁷ Some authors specify three elements of an autonomous action.³⁸ These elements include intentionality, understanding and noncontrol.³⁹ The first element is self-explanatory—either a person's act⁴⁰ is intentional or not. The other two elements are a matter of degree,⁴¹ therefore, they vary from person to person.

The "understanding" element requires that the actor understand his or her own action.⁴² This condition has special importance in relation to informed

³⁰Mary E. Rosen, *The Do Not Resuscitate Policy Jurisdiction Over Policy and the Therapeutic Privileges*, ABA FORUM COMM. ON HEALTH LAW 3 (Spring/Summer 1990).

³¹Y.H. Thong, *The Social Filter Effect of Informed Consent in Clinical Research*, 87 PEDIATRICS 568 (1991).

³²*Id.*

³³*Id.*

³⁴"Coercion may take the form of subtle pressure from other individuals, unconscious motivations, or simple failures to comprehend information in the form in which it is conveyed." Notes, *supra* note 5, at 1657.

³⁵*Id.*

³⁶*Id.*

³⁷Arthur L. Caplan, *A History and Theory of Informed Consent*, 257 JAMA 386 (1987) (Book Review). See also WEBSTER'S NEW WORLD DICTIONARY OF THE AMERICAN LANGUAGE (David B. Guralnik ed. 1984) (defining consent as 1. permission; approval 2. agreement).

³⁸See FADEN & BEAUCHAMP, *supra* note 27, at 238.

³⁹*Id.*

⁴⁰The patient's act referred to here is that of voluntarily submitting to a proposed treatment by the physician.

⁴¹See FADEN & BEAUCHAMP, *supra* note 27, at 238.

⁴²*Id.* at 248.

consent. Clinical experience has indicated that patients vary in their understandings of important information about diagnoses, medical procedures, risks of treatments and prognoses expected.⁴³ Such things as the level of calmness exhibited by the patient and any distractions to the patient affects one's ability to understand.⁴⁴ Within the realm of autonomy and informed consent, understanding is viewed as a patient's understanding that they must consent to or refuse a particular treatment.⁴⁵ Such consent or refusal is possible by understanding what that treatment is, through discussions with the treating physician.⁴⁶

The element of noncontrol is based on the fundamental principle that autonomous decisions are made independent of external controls upon a person.⁴⁷ A person should be able to exercise their free power of choice, without intervention of any element of force, fraud, deceit or duress.⁴⁸

For consent to be valid, the patient must have been given sufficient information to understand the nature of the decision that they made.⁴⁹ The process of obtaining informed consent must follow specific guidelines. Although sources of information such as a videotaped presentation or a discussion with a nurse can be used to supplement what the treating physician discusses, these secondary sources cannot take the place of an informative meeting with the primary treating physician.⁵⁰ The discussion in the course of obtaining informed consent should include such information as an explanation of the technique to be performed, risks involved, benefits and alternatives of the procedure, and prognosis both with and without treatment.⁵¹

In discussing the risks involved, those risks connected to the anesthesia should also be explained, even though these risks should be covered by the anesthetist.⁵² Generally, however, only material risks must be disclosed.⁵³ The

⁴³*Id.*

⁴⁴*Id.*

⁴⁵See FADEN & BEAUCHAMP, *supra* note 27, at 250.

⁴⁶*Id.*

⁴⁷*Id.* at 256.

⁴⁸*Id.*

⁴⁹Jeffrey R. Botkin, *Informed Consent for Lumbar Puncture*, 143 AM. J. OF DISEASES OF CHILDREN 899 (1989).

⁵⁰Marvin F. Kraushar, *Informed Consent; Surrender or Salvation?*, 104 ARCH. OPHTHALMOLOGY 352, 353 (1986).

⁵¹*Id.*

⁵²*Id.*

⁵³Jon R. Waltz & Thomas W. Scheuneman, *Informed Consent to Therapy*, 64 NW. U. L.REV. 628, 638 (1970). "Materiality is the keystone of the physician's duty to disclose." *Id.* The first task is to assess the risks and determine which ones are material. *Id.*

focus of "materiality" is the importance of the information to the patient.⁵⁴ Materiality has two components when analyzing risk:⁵⁵ probability and consequence.⁵⁶ As cited by the Massachusetts Supreme Court:

The materiality of information about a potential injury is a function not only of the severity of the injury, but also of the likelihood that [the injury] will occur. Regardless of the severity of a potential injury, if the probability that the injury will occur is so small as to be practically nonexistent, then the possibility of that injury occurring cannot be considered a material factor in a rational assessment of whether to engage in the activity that exposes one to the potential injury.⁵⁷

On the other hand, more common lesser risks must also be discussed since failing to do so leaves the doctor open to liability.⁵⁸ A patient may allege that he agreed to the procedure because the serious risks were remote and that with knowledge of the more common, lesser risks, he would not have given his consent.⁵⁹ However, everyday risks such as the possibility of surgery-related infections, need not be disclosed to the patient.⁶⁰ There is no need to disclose risks that either ought to be known by everyone⁶¹ or that are in fact known to the patient because of prior experience with the therapy in question.⁶² Furthermore, physicians will be held liable only for non-disclosure of risks which would be known to a reasonably prudent practitioner.⁶³ "[C]ourts have repeatedly stated that doctors are not insurers."⁶⁴

2. "Professional" Standard v. "Reasonable Person" Standard for Disclosure of Information

The duty to disclose can be determined by two different standards. The first standard, which seems to be the majority, is the "professional" or "medical

⁵⁴Jon F. Merz, *On a Decision-Making Paradigm of Medical Informed Consent*, 14 J. LEGAL MED. 231, 233 (1993).

⁵⁵*Id.*

⁵⁶*Id.*

⁵⁷*Precourt v. Frederick*, 481 N.E.2d 1144, 1148 (Mass. 1985).

⁵⁸*See Kraushar, supra* note 50, at 353.

⁵⁹*Id.*

⁶⁰*See Notes, supra* note 5, at 1637.

⁶¹*Roberts v. Young*, 119 N.W.2d 627 (Mich. 1963).

⁶²*Yeates v. Harms*, 393 P.2d 982 (Kan. 1964).

⁶³*Id.*

⁶⁴Milton Oppenheim, *Informed Consent to Medical Treatment*, 11 CLEV. ST. L. REV. 249, 259 (1962).

community" model of physician disclosure.⁶⁵ Here, a patient's right to know depends upon whether a reasonable medical practitioner would have disclosed the information under the same or similar circumstances.⁶⁶ In other words, under this standard of disclosure, the doctor need only disclose such risks that are consistent with the practice of the local community.⁶⁷ The doctor's choice of plausible courses should not be called into question if it appears that the doctor was motivated only by the patient's best therapeutic interests and that he proceeded as a competent medical professional would have done in a similar situation.⁶⁸

The second standard used to determine disclosure requirements is the reasonable patient standard. As stated by the court in *Canterbury v. Spence*,⁶⁹ "[r]espect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves."⁷⁰ "[T]he issue on nondisclosure must be approached from the viewpoint of the reasonableness of the physician's divulgence in terms of what he knows or should know to be the patient's information needs."⁷¹ This standard measures a physician's duty to disclose according to what an objective, "reasonable patient" would consider to be material to the decision about whether or not to consent to the proposed treatment.⁷² Thus, all risks potentially affecting the patient's decision must be revealed.⁷³ The reasonable person standard recognized that patient autonomy is limited, and that there must be tradeoffs which necessarily remove some choice from the individual.⁷⁴

Proponents of the reasonable person standard believe that the primary purpose of the informed consent doctrine is further promoted by focusing on a patient's need to obtain information pertinent to decision-making.⁷⁵ As stated

⁶⁵Halle F. Terrion, *Informed Choice: Physician's Duty to Disclose Non-Readily Available Alternatives*, 43 CASE W. RES. L. REV. 491 (1993); see also Metz, *supra* note 54.

⁶⁶Natanson v. Kline, 350 P.2d 1093, 1106 (Kan. 1960). See also Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 317 P.2d 170 (Cal. 1957).

⁶⁷See Notes, *supra* note 5, at 1637.

⁶⁸Tatro v. Lueken, 512 P.2d 529, 537 (Kan. 1973).

⁶⁹464 F.2d 772 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064.

⁷⁰*Id.* at 784.

⁷¹*Id.* at 787.

⁷²*Id.* at 786 (measuring the scope of doctor's communication to the patient by the patient's need).

⁷³*Id.* at 787.

⁷⁴See Beatty, *supra* note 29, at 711.

⁷⁵Sard v. Hardy, 379 A.2d 1014, 1021 (Md. 1977).

in *Canterbury*, the patient's right to decide whether to undergo a proposed therapy "is at the very foundation of the duty to disclose."⁷⁶

In viewing the "professional" standard, there is strong argument that this test runs contrary to the vesting of ultimate determination of treatment questions in the patient.⁷⁷ The patient's right to select treatment is limited due to the fact that it is based only on information deemed necessary to disclose according to the medical community.⁷⁸ So, although it may be in only the minority of jurisdictions, the reasonable person standard seems more logical to the promotion of the basis of informed consent.

B. What Type Of Information Must Be Disclosed?

*Schloendorff v. Society of New York Hospital*⁷⁹ is ordinarily viewed as one of the earliest cases involving the physician's duty to disclose information in order to obtain informed consent. Justice Cardozo made the historical statement "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ."⁸⁰ Since that time, there have been many opinions about what exactly must be disclosed to constitute an informed consent.⁸¹ Generally, the current legal standard requires the physician to disclose to the patient his diagnosis, the prognosis with and without the proposed treatment, and the alternatives for treatment, including the risks and benefits of each alternative.⁸² The necessity and extent of disclosure by a physician can be summarized by the following rules:

[I]n order to assure that an informed consent is obtained, the physician must make the disclosures necessary to form the basis of such a consent, but the duty of the physician is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances. The nature and extent of the disclosure depends upon the medical problem as well as upon the patient. It has

⁷⁶*Canterbury*, 464 F.2d at 786.

⁷⁷See Notes, *supra* note 5, at 1638.

⁷⁸*Id.*

⁷⁹105 N.E. 92 (N.Y. 1914).

⁸⁰*Id.* at 93.

⁸¹Justice Cardozo's sentiment was further expressed in a report by the PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS: THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP Washington D.C., 1982. The report states that even if no legal doctrine of informed consent existed, the moral imperative of preserving the individual's right to choose what happens to his or her body would mandate faithful compliance with the principle of informed consent. WILLIAM J. CURRAN ET AL., HEALTH CARE LAW, FORENSIC SCIENCE, AND PUBLIC POLICY 314 (4th ed. 1990).

⁸²See Botkin, *supra* note 49, at 899.

been suggested that some disclosures may so disturb the patient that they serve as hindrances to needed treatment, and certain disclosures in some instances may even be bad medical practice.⁸³

The requirement of disclosing prognosis information to terminally ill patients ranks as one of the most controversial topics within this area. "Prognosis" is defined as "a prediction," especially in the course of a disease.⁸⁴ A therapeutic privilege not to disclose information when it may be harmful to the patient has been recognized.⁸⁵ Some believe prognosis information can be detrimental to the patient, especially where terminal illness is concerned. However, the patient's express purpose for employing the services of the doctor may dictate whether or not certain information can be withheld.

In one situation, the patient comes to the doctor specifically for the purpose of gaining the advantage of a diagnosis and prognosis for informational purposes only.⁸⁶ Here, the patient, in coming to a particular specialist, is asking for a precise diagnosis and prognosis.⁸⁷ Although the doctor could decline the employment offered by the patient, if he proceeds, "he must realize that the giving of information [good or bad] has been made the essence of his engagement."⁸⁸ Often, such services are engaged as a basis for arranging personal affairs upon notice of "the worst possible facts about one's physical condition."⁸⁹ As rare as it may be, in such a situation, the doctor has a duty to disclose the information once he has entered upon the undertaking.

A more complex situation occurs when the patient engages the doctor to treat him, and the diagnosis comes secondary to that end.⁹⁰ In such cases, many argue that the privilege to withhold information should apply because "[s]udden disclosure of a dread[ed] disease may cause tremendous repercussions in the patient."⁹¹ In most situations where the privilege would not apply, the doctor should also disclose the patient's diagnosis and prognosis to constitute full disclosure.

⁸³Tatro, 512 P.2d at 538 (citing 61 AM.JUR.2D *Physicians, Surgeons, Etc.*, § 154 (1981)).

⁸⁴WEBSTER'S NEW WORLD DICTIONARY OF THE AMERICAN LANGUAGE (David B. Guralnik ed. 1984). Prognosis is also defined as the foretelling of the probable course of a disease. STEDMAN'S POCKET MEDICAL DICTIONARY 612 (William R. Hensyl ed. 1987).

⁸⁵See *infra* notes 92-102 and accompanying text.

⁸⁶Hubert W. Smith, *Therapeutic Privilege to Withhold Specific Diagnosis From Patient Sick With Serious or Fatal Illness*, 19 TENN. L. REV. 349, 352 (1946).

⁸⁷*Id.*

⁸⁸*Id.*

⁸⁹*Id.*

⁹⁰See Smith, *supra* note 86, at 354.

⁹¹*Id.*

C. The Therapeutic Privilege to Informed Consent

In addition to holding that the appropriate standard for disclosure was a patient-centered standard as opposed to the professional standard, the court in *Canterbury* recognized the "therapeutic privilege" exception to the disclosure of risk information.⁹² This exception is "a recognition that as important as is the patient's right to know, it is greatly outweighed by the magnitudinous circumstances giving rise to the privilege."⁹³ This privilege applies when risk-disclosure poses such a threat of detriment to the patient that it becomes unfeasible or inadvisable from a medical point of view.⁹⁴

It is acknowledged that patients occasionally become so ill or emotionally distraught upon disclosure of medical information so as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient.⁹⁵ One court specifically suggested that information may be properly withheld from the patient if its disclosure "might induce an adverse psychosomatic⁹⁶ reaction in a patient highly apprehensive of his condition."⁹⁷ One strong supporter of the privilege wrote,

To tell the patient the truth and the whole truth often causes violent psychological reactions to the patient and an undermining of morale without any countervailing gain. In the ordinary case, it may indeed be negligent medical practice to worsen the patient's condition and to destroy or impair his chances of recovery by such injudicious disclosures.⁹⁸

According to the *Canterbury* court, the critical inquiry in application of the privilege is whether the doctor showed sound medical judgment in deciding

⁹²464 F.2d at 789.

⁹³*Id.* at 788. The court did acknowledge the fact that even if the privilege applies to the situation, the doctor should attempt to secure a relative's consent if possible. *Id.* at 789. In fact, the Italian Deontology Code, written by the Italian Medical Association included the following statement: "A serious or lethal prognosis can be hidden from the patient, but not from the family." Antonella Surbone, *Letter From Italy: Truth Telling to the Patient*, 268 JAMA 1661 (1992).

⁹⁴464 F.2d at 789. See also Meisel & Kabnick, *Informed Consent to Medical Treatment: An Analysis of Recent Legislation*, 41 U. PITT. L. REV. 407, 444 (1980).

⁹⁵464 F.2d at 789.

⁹⁶The term psychosomatic is used to refer to the relationship between the psychological and the physiological. Bradford Wixon, *Therapeutic Deception*, 13 J.LEG.MED. 77 (1992). In recent years, there has accumulated convincing evidence that the immune system, along with other organs and systems in the body, can be influenced by the mind. See MIND BODY MEDICINE, *infra* note 247, at 4.

⁹⁷*Nishi v. Hartwell*, 473 P.2d 116, 121 (Haw. 1970).

⁹⁸Smith, *supra* note 86, at 354. Another supporter, in writing an article favoring the therapeutic privilege, dedicated his work to his father-in-law, who "might likely have lived longer, had his physicians offered him hope." Wixon, *supra* note 96, at 77.

that communication of risk information would present a threat to the patient's well-being.⁹⁹ The doctor should assess the risks and benefits of truth telling on the basis of current scientific knowledge, rather than on folklore or his own personal discomfort.¹⁰⁰ The court continued by stating that a doctor is not privileged to withhold information from a patient merely because divulgence might prompt the patient to forego the therapy which the doctor believes the patient needs.¹⁰¹ This may especially apply in the situation of a terminally ill patient. Upon disclosure that the patient's condition has become terminal, oftentimes cancer patients choose to forego any further chemotherapy treatments and concentrate on the quality of the time they have left.¹⁰² If a doctor withholds prognosis information which suggests a terminal illness simply because he believes the patient will forego the proposed treatment or choose another alternative, the doctor will be liable for non-disclosure and held responsible for damages.¹⁰³

D. Damages For Failure to Disclose

Originally, a claim for lack of informed consent sounded in battery.¹⁰⁴ Battery law provides that a defendant may be liable for all injury caused by tortious touching.¹⁰⁵ Such a claim gives rise to compensatory damages, which "represent the amount of the pecuniary injury actually suffered[.]" as well as punitive damages, which are "designed to punish and deter intentional wrong doing."¹⁰⁶ Absent any physical injury, nominal damages may be assessed for an insult suffered.¹⁰⁷

Although informed consent claims originated in battery, the courts soon recognized the claim¹⁰⁸ as one arising in negligence.¹⁰⁹ In the great majority of

⁹⁹464 F.2d at 789. Some believe that discussion with the patient's family can be utilized to ascertain whether risk-disclosure to the patient will, in fact, seriously interfere with the patient's decision-making capacity. See Meisel, *supra* note 14, at 466.

¹⁰⁰Maxwell Boverman, *Truth Telling in Medicine*, 248 JAMA 1307 (1982).

¹⁰¹*Id.* See also, *Hook v. Rothstein*, 316 S.E.2d 690, 703 (S.C. 1984).

¹⁰²See *infra* note 266 and accompanying text.

¹⁰³See Boverman, *supra* note 100.

¹⁰⁴A battery is an intentional and wrongful physical contact with a person without his or her consent that entails some injury or offensive touching. BLACK'S LAW DICTIONARY 104 (Abridged 6th ed. 1991).

¹⁰⁵See Merz, *supra* note 54, at 233.

¹⁰⁶See Oppenheim, *supra* note 64, at 249.

¹⁰⁷See Merz, *supra* note 54, at 233.

¹⁰⁸A typical claim regarding informed consent might read as follows:
[Dr.] failed and omitted to give the plaintiff sufficient facts and information concerning the procedure so that the plaintiff could reasonably decide whether he was willing to undergo the surgical procedure; [Dr.] failed and

American jurisdictions, an action is based in negligence.¹¹⁰ If the patient would not have consented to the operation or treatment had he been warned of a consequence, and the consequence actually occurred, then the action is for malpractice.¹¹¹ As one writer said, "[t]he fundamental distinction between ordinary assault and battery and medical negligence such as would constitute malpractice, is that the former is intentional and the latter unintentional."¹¹² Under a negligence theory, a successful suit will depend on the plaintiff's ability to demonstrate five key elements in an informed consent case: (1) the physician's duty owed to the patient to provide information; (2) breach of the physician's duty; (3) harm suffered by the patient; (4) the relation of the harm to the development of an undisclosed risk; and (5) evidence that had the patient been informed of the risk, he or she would not have consented to the procedure.¹¹³

In *Natanson v. Kline*, the court stated in dicta that the measure of damages for failure to secure an informed consent is the loss¹¹⁴ resulting from the risk which materialized, whether or not the therapy was performed carefully.¹¹⁵

In addition to proving a loss due to the doctor's malpractice, a plaintiff in a suit for damages based on lack of informed consent must establish proximate causation between the asserted breach of duty and the resultant injury. In the event that the plaintiff can fulfill the key elements in an informed consent case, and no exception to the doctrine applies, the plaintiff may recover if he or she proves the necessary causation.

omitted to inform the plaintiff of the risks and/or alternatives of the said surgical procedure.

See Kraushar, *supra* note 50, at 353.

¹⁰⁹*Id.*

¹¹⁰John H. Derrick, Annotation, *Medical Malpractice: Liability for Failure of Physicians to Inform Patient of Alternative Modes of Diagnosis or Treatment*, 38 A.L.R. 4TH 900 (1985). Basically, the only exceptions where a battery action may still be brought are situations where the procedure is forced upon the patient without any consent, or where the consent is fraudulently obtained and the fraud relates to the character of the touching. See Curran, *supra* note 81, at 304.

¹¹¹*Hales v. Pittman*, 576 P.2d 493, 502 (Ariz. 1978).

¹¹²See Oppenheim, *supra* note 64, at 259.

¹¹³See FADEN & BEAUCHAMP, *supra* note 27, at 23-49.

¹¹⁴Some losses which might be asserted in a damage action are loss of enjoyment of life and lost wages. See Beatty, *supra* note 29, at 712.

¹¹⁵350 P.2d at 1107 (holding that an issue for the jury to determine should be whether the administration of cobalt irradiation treatment was given with the informed consent of the patient, and if informed consent was not given, the doctor who failed in his legal obligation is guilty of malpractice no matter how skillfully the treatment may have been administered, and the jury should determine the damages arising from the irradiation treatment).

III. CONDITIONS THAT MANDATE DISCLOSURE AND CONDITIONS THAT RECOMMEND CAUTION

Conditions that require disclosure vary from patient to patient. The most obvious example of a situation which warrants disclosure is when the patient specifically asks for his diagnosis and/or prognosis. If a patient asks for her diagnosis or prognosis, she certainly wants to know the results and deserves to know them.¹¹⁶ Patients know their limits better than anyone else and if they ask for the results, it is usually because they feel they can handle it. Also, it is often thought that patients who ask for a prognosis suspect their illness is serious,¹¹⁷ and the process of "wondering" whether or not it is serious is often even more stressful than hearing the "bad news." Denial of death within our society has made many people unable to appreciate that a dying person may accept the prospect of death "with equanimity and without mental disturbance."¹¹⁸

While medical providers have a duty to provide information to patients who ask, there are some situations where caution is recommended. The most obvious example of such a situation is when a patient has expressly voiced suicidal intentions. One writer¹¹⁹ used the following example: A woman had a lump in her breast which was medically recognizable as cancer. She went to a reputable surgeon in a rather distraught frame of mind. At the outset of the interview, she told the surgeon that if she had cancer she would commit suicide.¹²⁰ Due to the psychological condition of the patient and her threat of self-destruction, the surgeon told her she had a tumor that needed to be removed but did not specify that the tumor was cancerous.¹²¹ The patient was successfully treated but when she subsequently found out that it had been cancerous, she brought a claim for malpractice.¹²² In reply, it was asserted that her own threats of self-destruction raised a therapeutic privilege to withhold the true facts in her case.¹²³ As rare as this situation may be, this author believes

¹¹⁶Surprisingly, the majority of doctors in one survey felt that almost all patients really do not want to know about their illness, regardless of what they say when asked. See Oken, *supra* note 3, at 1123. Interestingly enough, the same survey showed that the doctors would want to be told the whole truth, if they themselves were the patients. *Id.* at 1125.

¹¹⁷Some believe it is naive to assume that professionals and family members can successfully conceal awareness of a terminal illness from a patient. See High, *supra* note 2, at 6.

¹¹⁸E. KUBLER ROSS, ON DEATH & DYING 112-137 (1969).

¹¹⁹See Smith, *supra* note 86, at 355.

¹²⁰*Id.*

¹²¹*Id.*

¹²²*Id.*

¹²³See Smith, *supra* note 86, at 355.

that the privilege should be strictly construed and allowed only in such limited situations.

A. Therapeutic Privilege as a Defense to Medical Malpractice

"When an exception to the informed consent doctrine is properly invoked, the physician is relieved of either his duty of disclosure, or his duty of obtaining consent from the patient, or both."¹²⁴ The basic canons of malpractice must be recorded: the doctor must behave as a reasonable doctor and as a reasonable person.¹²⁵

In *Cobbs v. Grant*, the court established an objective test for causation that holds the doctor liable only if the trier of fact decides that a reasonable person in the patient's position would have refused the treatment when adequately informed.¹²⁶ Some evidence demonstrates that courts may closely analyze a doctor's invocation of the privilege of therapeutic deception¹²⁷ as a defense.¹²⁸ For this reason, a doctor would be well advised not to rely upon this defense unless the patient's mental condition and the harm disclosure would cause are well documented.¹²⁹

For a doctor to be sure he is complying with the legal doctrine of informed consent, he should always ask the patient two questions following his discussion of the proposed treatment.¹³⁰ First, he should ask the patient whether he understands the procedure or therapy that was discussed.¹³¹ Second, the patient should also be asked whether he has any questions regarding the material discussed.¹³² Asking these questions and receiving the appropriate responses will help to protect the doctor from any later claim by the patient that he was hurried through the decision and not given an oppor-

¹²⁴See Meisel, *supra* note 14, at 470.

¹²⁵See Waltz & Scheuneman, *supra* note 53, at 649-650.

¹²⁶502 P.2d 1, 11-12 (1972).

¹²⁷Deception has been defined by one writer as not involving direct lying, but involving "evasive or misleading statements which are nonetheless true." Mark Sheldon, *Truth Telling in Medicine*, 247 JAMA 651, 652 (1982) (Special Communications Section) (quoting Ellin, J., *Lying & Deception*, WESTMINSTER INST. REV. 3-6 (1981)).

¹²⁸Richard E. Shugre & Kathryn Linstromberg, *The Practitioner's Guide to Informed Consent*, 24 CREIGHTON L. REV. 881, 907 (1991).

¹²⁹*Id.* To document a patient's high susceptibility to anxiety, confirmation of the doctor's observations by another medical person and/or a relative or close friend of the patient should be sought and entered on the patient's treatment record. *Id.* at 907. For an interesting overview of malpractice defenses, see Michael J. Farrell, *Medication Malpractice: Claims, Culprits and Defenses*, 16 AM. J. TRIAL ADVOC. 65 (1992).

¹³⁰See Kraushar, *supra* note 50, at 353.

¹³¹*Id.*

¹³²*Id.*

tunity to fully consider the facts presented.¹³³ As added security, the doctor might give the patient some period of time, perhaps a day or so depending on the circumstances surrounding the illness or injury, to think about and process all the information he has received. Obviously, this is not possible in emergency situations, but "[t]he right of action to recover for medical malpractice based on a lack of informed consent is limited to those cases involving . . . non-emergency treatment"¹³⁴

B. Others' Ability to Cause Non-disclosure to Patients

There are often times when various family members, such as spouses or parents, may wish to withhold information from a patient. Such individuals assume a terminally ill person will believe what they hear, rather than acknowledge the signals they receive from their own bodies.¹³⁵ This often causes an ethical dilemma for the practitioner: a contrast between the duty to respect the family's wishes versus the duty to tell the truth to the patient.¹³⁶ Often, family members, especially parents, are devastated when they are told that the patient has a chronic or fatal disease.¹³⁷ In some cases, family members agree not to tell anyone and to refuse to allow the health care professionals to disclose the diagnosis and/or prognosis to the patient.¹³⁸ This often causes stress not only to the doctor, but also to the other health care professionals involved in the patient's treatment.¹³⁹ Decisions about disclosure must be made by considering the specific details of the case, taking into account such considerations as physician factors, disease-specific factors, patient factors and family factors.¹⁴⁰

Perhaps the greatest physician factor is that physicians differ in their approaches to disclosure decisions. For some, the therapeutic privilege is a justifiable alternative to full disclosure.¹⁴¹ Other doctors feel that any deception

¹³³*Id.*

¹³⁴See Meisel & Kabnick, *supra* note 94, at 446 (citing N.Y. PUB. HEALTH LAW § 2805-d(2) (McKinney 1977)).

¹³⁵See High, *supra* note 2, at 8.

¹³⁶Garry Sigman, M.D., *Disclosure of a Diagnosis to Children and Adolescents When Parents Object*, 147 AM. J. OF DISEASES OF CHILDREN 764 (1993).

¹³⁷*Id.*

¹³⁸*Id.* at 765.

¹³⁹See *infra* notes 241-246 and accompanying text.

¹⁴⁰See Sigman, *supra* note 136, at 765.

¹⁴¹According to one study, "a vast majority of doctors feel that almost all patients really do not want to know regardless of what [they] say." See Oken, *supra* note 3, at 1123. "They approach the issue with the view that disclosure should be avoided unless there are positive indications, rather than the reverse." *Id.*

toward the patient is wrong under any circumstances.¹⁴² This is often an expression of the doctor's personal values derived from religious, social and familial influences.¹⁴³ These physician factors have a definite effect on disclosures made over a family member's objection.

Disease-specific factors also affect whether a physician will disclose information when requested by others not to disclose.¹⁴⁴ "A strong argument for disclosure exists if a [patient's] knowledge of the disease positively affects its course and prognosis."¹⁴⁵ Diseases such as diabetes mellitus and severe cystic fibrosis are diseases requiring much self-care, and survival would be unlikely without a patient's knowledge of the disease and continuation of daily self-care.¹⁴⁶ Also, the duty to disclose to the patient, over family objections, increases as the potential threat to the public increases.¹⁴⁷ Some diseases, such as Human Immunodeficiency Virus and hepatitis B, cannot be hidden because of the potential for unwitting transmission.

Patient-specific factors can also have some effect on a physician's disclosure of information to that patient. One such factor is age.¹⁴⁸ As a young adult matures he has increasing "moral authority to think, speak and act for himself."¹⁴⁹ This advancing maturity of the patient raises the value of the patient's right to know personal information regarding his illness above a parent's right to control that information.¹⁵⁰ Also, the doctor must consider the history and examination of the patient and decide whether the patient is at a high risk for psychiatric symptoms before making any and all disclosures.¹⁵¹

Finally, the physician should consider family factors in determining whether or not to abide by the family's request for non-disclosure. Obviously, cultural backgrounds and beliefs differ from family to family.¹⁵² "Families differ in how, when and where they make decisions."¹⁵³ Physicians must evaluate and

¹⁴²A doctor's decision to deceive a patient may threaten the patient's trust and the quality of their physician-patient relationship. Dennis H. Novack, M.D., et al., *Physicians' Attitudes Toward Using Deception to Resolve Difficult Ethical Problems*, 261 JAMA 2980 (1989).

¹⁴³See Sigman, *supra* note 136, at 766.

¹⁴⁴*Id.*

¹⁴⁵*Id.*

¹⁴⁶See Sigman, *supra* note 136, at 766.

¹⁴⁷*Id.*

¹⁴⁸*Id.*

¹⁴⁹*Id.*

¹⁵⁰See Sigman, *supra* note 136, at 766.

¹⁵¹*Id.* at 767.

¹⁵²*Id.*

¹⁵³*Id.*

respect the decision-making process in families when faced with dilemmas regarding disclosure issues.¹⁵⁴ However, especially in the case of minor patients, there have been limits on the ability of the family to make medical decisions which may not be in the patient's best interest.¹⁵⁵

Decisions regarding truth telling are case specific and should be continually revised as the clinical situation changes.¹⁵⁶ For example, patients who are diagnosed with a chronic disease when they are very young can, in some situations, justifiably have information withheld from them due to their immaturity. However, as the patient grows and matures, the numerous factors involving disclosure must be re-evaluated to determine whether or not the non-disclosure is still justified.

C. Doctors' View to Disclosure of the Fatality of Diseases

Physicians, by virtue of their responsibility for medical judgments are, partly by choice and partly by default, charged with the responsibility of making ethical judgments which [they] are sometimes ill-equipped to make.¹⁵⁷

Although there are legitimate scholastic issues involved in a doctor's decision-making, it is anything but an academic situation to the doctor, the patient and his family.¹⁵⁸ Doctors, however, often become involved.¹⁵⁹

Doctors handle the disclosure of "bad news" in a variety of ways. They either avoid the whole issue of death and dying, are upfront with the patient and tell them anything they want to know, or force upon the patient all known information in an attempt to avoid later litigation.¹⁶⁰

Evidence suggests that non-disclosure to dying patients is a usual practice among doctors.¹⁶¹ Strong believers in the therapeutic privilege feel that a dying patient would be shocked, depressed, or otherwise adversely affected if he were given the facts.¹⁶² Others feel that the patient commonly knows he is dying anyway.¹⁶³

¹⁵⁴See Sigman, *supra* note 136, at 767.

¹⁵⁵*Id.* at 764.

¹⁵⁶*Id.* at 768.

¹⁵⁷Karen Teel, *The Physician's Dilemma - A Doctor's View: What the Law Should Be*, 27 BAYLOR L.REV. 6, 8 (1975).

¹⁵⁸*Id.* at 9.

¹⁵⁹*Id.*

¹⁶⁰See Surbone, *supra* note 93, at 1661.

¹⁶¹Note, *Informed Consent and the Dying Patient*, 83 YALE L.J. 1632, 1658.

¹⁶²*Id.*

¹⁶³*Id.*

One preliminary survey intimates that the majority of physician-respondents are inclined to use deception in at least some situations when confronted by conflicting moral values.¹⁶⁴ This is very important because a doctor's decision to use deception will effect patient trust and the quality of physician-patient relationships.¹⁶⁵ In answering the questions concerning their attitudes and practices, the majority of the respondents believed that their patients did not expect them to use deception and that they never or rarely used deception with their patients.¹⁶⁶

In an effort to be kind, helpful and positive, doctors frequently¹⁶⁷ deceive patients as to their true beliefs.¹⁶⁸ There are many forms of deception, such as actively deceiving another by lying or using vague speech.¹⁶⁹ One can also passively deceive via nondisclosure by allowing someone else to deceive the patient or by failing to correct a misconception.¹⁷⁰

Some doctors may deceive via avoidance for their own benefit. Physicians may benefit from self-deception, as in believing that it is too uncomfortable for dying patients to discuss end-of-life issues, when it is really too uncomfortable for the doctors themselves.¹⁷¹ In another study used to determine whether or not doctors disclosed a diagnosis of cancer to their patients, there was found a strong general tendency to withhold such information.¹⁷² For those in the minority who chose the "tell often" option in the survey, there was a tendency to tell the patient that he had a "tumor," with rigid avoidance of specifications such as cancer and malignancy.¹⁷³ Such words were almost never used unless the patient was persistent in his questioning and the doctor had no choice.¹⁷⁴

¹⁶⁴See Novack, *supra* note 142, at 2983.

¹⁶⁵*Id.* at 2980. Physicians were asked an open-ended question pertaining to their basic principles regarding their use of deception toward patients. *Id.* at 2983. One participant in this survey answered the questions regarding principles as follows: "... the only basic policy is first to do no harm. Honesty is usually the best policy." *Id.*

¹⁶⁶See Novack, *supra* note 142, at 2983.

¹⁶⁷Although doctors may frequently deceive their patients, they still believe that their patients do not expect them to use deception. *Id.*

¹⁶⁸See Novack, *supra* note 142, at 2984.

¹⁶⁹*Id.*

¹⁷⁰*Id.*

¹⁷¹See Novack, *supra* note 142, at 2984.

¹⁷²See Oken, *supra* note 3, at 1122.

¹⁷³*Id.* at 1123.

¹⁷⁴*Id.*

One system used by many doctors was to tell as little as possible in the most general terms that still encouraged cooperation by the patient.¹⁷⁵ "Many approach the issue with the view that disclosure should be avoided unless there are positive indications [for] disclosure"¹⁷⁶ such as emotional stability and an expressed interest to know the information.

All doctors who believed non-disclosure was the better alternative stated "a single major goal: maintenance of hope."¹⁷⁷ When interviewed, they stated their determined purpose as "bolster[ing] the patient's hope."¹⁷⁸ Some doctors stated that knowledge of cancer is "a death sentence."¹⁷⁹ This pessimism toward such diseases is apparent in society in general and among doctors themselves.¹⁸⁰ The general feeling is that doctors "can do very little to save lives and not a great deal to prevent suffering."¹⁸¹ There is a great amount of frustration associated with waiting "helplessly," while a patient is facing a fatal illness.¹⁸² "In matters of life and death, [one's] personal [observations are] far too likely to be subject to personal unconscious distortions."¹⁸³

The flip side to non-disclosure by doctors is excessive disclosure of information to the patient. To some doctors, every patient is a potential adversary.¹⁸⁴ Hence, they may "communicate vast amounts of complicated information to unprepared patients purely out of fear of litigation."¹⁸⁵ This "result[s] in exhaustive lists of information that will not improve the [doctor]-patient relationship."¹⁸⁶ It leaves the patient feeling confused and may cause him to forego some treatment that has only minor, remote risks and a high success rate. This is not truly informed consent since the patient is not really "informed." More likely than not, he is just scared and confused.

There is also evidence to suggest that fear of litigation causes what has become known as defensive medicine. Defensive medicine is "unnecessary

¹⁷⁵*Id.* Though, most doctors surveyed agreed that some family member should be informed even if the diagnosis is withheld from the patient. See Oken, *supra* note 3, at 1123.

¹⁷⁶*Id.*

¹⁷⁷*Id.*

¹⁷⁸*Id.*

¹⁷⁹See Oken, *supra* note 3, at 1125.

¹⁸⁰*Id.* at 1126.

¹⁸¹*Id.*

¹⁸²*Id.*

¹⁸³See Oken, *supra* note 3, at 1127.

¹⁸⁴WILLIAM J. CURRAN ET AL., HEALTH CARE LAW, FORENSIC SCIENCE, AND PUBLIC POLICY 313 (4th ed. 1990).

¹⁸⁵See Surbone, *supra* note 93, at 1661.

¹⁸⁶*Id.*

medical care prescribed [by the physician] solely to avoid malpractice claims."¹⁸⁷ The American Medical Association has estimated defensive medicine to cost almost \$25 billion per year.¹⁸⁸ This is a complex issue since fear of litigation is only one of its causes.¹⁸⁹ "The cost of defensive medicine is uncertain, and [any] benefits to patient health and safety are usually overlooked."¹⁹⁰

IV. CASE EXAMPLE: *ARATO V. AVEDON*

One recent paradigmatic case of informed consent and full and fair disclosure is *Arato v. Avedon*.¹⁹¹ This case proceeded through the California state court system, culminating with the September 30, 1993 opinion from the California Supreme Court.

A. Factual and Procedural History

Miklos Arato underwent surgery to remove a non-functioning kidney on July 21, 1980.¹⁹² During surgery, a tumor was discovered in the tail of his pancreas.¹⁹³ Upon an assessment by a fellow colleague which concurred in the judgment of Mr. Arato's doctor that the tumor should be removed, the situation was explained to Mr. Arato's wife and she consented to the additional surgery.¹⁹⁴ The excised specimen of tissue was sent to a pathologist for examination.¹⁹⁵ Several days later, the surgeon informed the Aratos that the tumor was in fact malignant.¹⁹⁶ Mr. and Mrs. Arato were not informed that this type of tumor tends to spread easily.¹⁹⁷

¹⁸⁷Kenneth Jost, *Defensive Medicine: Cost Savings Uncertain*, 79 A.B.A. J. 71 (May 1993).

¹⁸⁸*Id.*

¹⁸⁹*Id.* at 74.

¹⁹⁰*Id.*

¹⁹¹11 Cal. Rptr.2d 169 (1992).

¹⁹²*Id.* at 171.

¹⁹³*Id.*

¹⁹⁴*Id.*

¹⁹⁵11 Cal. Rptr.2d 169 (1992). Later that day, the surgeon met with Mr. and Mrs. Arato, described the surgical procedure performed, stated that he believed the tumor was cancerous, and explained that the findings would be forthcoming from the pathologist. *Id.*

¹⁹⁶Malignant is defined as: 1. Resistant to treatment; occurring in severe form, and frequently fatal; tending to become worse and lead to an ingravescence course. *STEDMAN'S POCKET MEDICAL DICTIONARY* 432 (William R. Hensyl ed. 1987).

¹⁹⁷11 Cal. Rptr. 2d at 171.

One month after his surgery, the Aratos met with Dr. Avedon, the oncologist to whom they were referred by Mr. Arato's surgeon.¹⁹⁸ Dr. Avedon proposed a form of therapy consisting of chemotherapy with a combination of drugs known as F.A.M.¹⁹⁹ and radiation treatments.²⁰⁰ Upon explanation, Mr. Arato decided to go ahead with the proposed therapy.²⁰¹

While filling out the initial paperwork at the oncologist's office, Mr. Arato indicated²⁰² that he wanted to be told the truth about his illness if he should become seriously ill in the future.²⁰³

Nine months after Mr. Arato's surgery, upon receipt of some test results, Dr. Avedon formed the opinion that it was highly likely that Mr. Arato had a recurrence of the cancer.²⁰⁴ It was Dr. Avedon's opinion that Mr. Arato's reasonable life expectancy would be short, measurable in months.²⁰⁵ Dr. Avedon did not share this information with Mr. Arato—he simply said that the test results suggested a recurrence of the disease.²⁰⁶

Two months later, Mr. Arato was admitted to the hospital where it was conclusively determined that his cancer had recurred and that he was beyond cure.²⁰⁷ Upon a brief discussion in which Mr. Arato was told his disease was no longer curable, Mr. Arato asked, "Where do we go from here?"²⁰⁸ Dr. Avedon

¹⁹⁸11 Cal. Rptr.2d at 171. Dr. Avedon informed the Aratos that there was a significant chance that the surgery to remove the tumor had not cured the disease and that Mr. Arato was at great risk for a recurrence. *Id.* The doctor continued by saying that if he should develop some recurrence, it would mean his disease was not cured, and that at this point his disease would then be incurable. *Id.*

¹⁹⁹"F.A.M." is a treatment employing a combination of drugs, which when used in conjunction with radiation therapy, has shown promise in treating pancreatic cancer in experimental trials. *Arato v. Avedon*, 858 P.2d 598, 600 (Cal. 1993).

²⁰⁰11 Cal. Rptr.2d at 171. The doctor explained that F.A.M. had demonstrated to be effective on some forms of pancreatic cancer but he also explained that there was the risk that this therapy would have no benefit at all. *Id.*

²⁰¹*Id.*

²⁰²Mr. Arato indicated his preference to be told the full truth via both a written questionnaire and verbal statements. *Id.*

²⁰³11 Cal. Rptr.2d at 172. Upon reviewing the pathology report, Dr. Avedon was of the opinion that it was highly likely that Mr. Arato would die of this disease and that he would probably live less than five years. *Id.* Dr. Avedon, however, did not convey this information to Mr. Arato since he had not specifically questioned him about a time frame. *Id.* Along with three other doctors, Dr. Avedon, provided chemotherapy and radiation therapy to Mr. Arato. *Id.* None of these doctors provided Mr. Arato with life expectancy information. 11 Cal. Rptr.2d at 172.

²⁰⁴*Id.*

²⁰⁵*Id.*

²⁰⁶*Id.*

²⁰⁷11 Cal. Rptr.2d at 172.

²⁰⁸*Id.*

said they could try to make things better so that he might have some good time ahead.²⁰⁹ At this point, Mr. Arato indicated²¹⁰ that he no longer wanted to discuss the situation.

Dr. Avedon then met with Mrs. Arato, told her about his conversation with her husband and expressed his view that Mr. Arato did not want to be further informed about his condition.²¹¹ At this point, Mrs. Arato determined that her husband should be given no further information about his condition.²¹² Mr. Arato was discharged two weeks later, was at home for approximately two weeks and then was rehospitalized.²¹³ He died four days later, just more than a year after his surgery that resulted in the removal of a tumor from his pancreas.²¹⁴

Mrs. Arato, along with her two adult children, brought an action against the surgeon and the four doctors involved in Mr. Arato's chemotherapy and radiation therapy.²¹⁵ The plaintiff's theory was that the defendant doctors had breached their fiduciary duty to make a full and fair disclosure of all facts which materially affected Mr. Arato's rights and interests.²¹⁶ Plaintiffs claimed that had they known Mr. Arato's true condition, they would have conducted their business and personal affairs differently.²¹⁷ It was contended that Mr. Arato might have chosen to forego the time-consuming and painful chemotherapy had he known that the common life expectancy with such a disease was so short.²¹⁸

At trial, there was extensive expert testimony regarding disclosure to a patient of life expectancy information.²¹⁹ The jurors were instructed and asked only to decide whether defendant doctors had disclosed all relevant information to enable Mr. Arato to make an informed decision regarding the proposed treatment.²²⁰ The jury returned a verdict for the defense and the plaintiffs appealed.²²¹

²⁰⁹*Id.*

²¹⁰"Mr. Arato waved Dr. Avedon away." *Id.* at 172.

²¹¹*Id.*

²¹²11 Cal. Rptr.2d at 172.

²¹³*Id.*

²¹⁴*Id.*

²¹⁵*Id.*

²¹⁶11 Cal. Rptr.2d at 172.

²¹⁷*Id.* at 173.

²¹⁸*Id.*

²¹⁹*Id.*

²²⁰11 Cal. Rptr.2d at 173.

²²¹*Id.* "The jury found (1) none of the defendants 'negligent in the medical management of the deceased, and (2) that defendants' disclosed to decedent . . . all

B. Appellate Court Discussion

On appeal, the Court of Appeals emphasized the prior California Supreme Court case of *Cobbs v. Grant*.²²² The court in *Cobbs* reasoned that in many instances, the particular treatment to be undertaken seems evident to the physician but that it is the patient's prerogative, not the doctor's, to determine for himself the direction in which he believes his interests to lie.²²³ Furthermore, "[t]o enable the patient to chart his course knowledgeably, reasonable familiarity with the therapeutic alternatives and their hazards becomes essential."²²⁴

The California Supreme Court in *Cobbs* strongly rejected the medical community standard for determination of what constitutes a full disclosure.²²⁵ The court continued by saying that once the doctor has disclosed the required information, the weighing of these risks rests with the patient.²²⁶ As stated in *Cobbs*, "... evaluation and decision is a nonmedical judgment reserved to the patient alone."²²⁷

The appellate court in *Arato* held that without information concerning the characteristics of the specific kind of cancer involved, including its affect on the patient during its progression, there was no way for the patient to intelligently assess any information provided.²²⁸ This seems especially true where the treatment has significant side effects and an extraordinary low probability of success.²²⁹ The court reasoned that when a patient has requested the truth, the doctor does him an injustice by withholding precise, specialty information.²³⁰ A divided Court of Appeals reversed the judgment of the trial court, and ordered a new trial.²³¹ The Supreme Court of California granted the defendant's ensuing petition for review.²³²

relevant information which would have enabled [Mr. Arato] to make an informed decision regarding the proposed treatment to be rendered him." *Id.* at 173.

²²²502 P.2d 1 (Cal. 1972).

²²³*Id.* at 10.

²²⁴*Id.*

²²⁵*Id.*

²²⁶502 P.2d at 10.

²²⁷*Id.*

²²⁸11 Cal. Rptr.2d at 177.

²²⁹*Id.*

²³⁰*Id.* at 178. Here, the court acknowledged that very often patients receive information and misinformation from other, unreliable sources. *Id.* The doctor would do well to communicate the correct information to the patient so that the patient isn't confused by all the "helpful" information offered by friends, family and co-workers.

²³¹*Arato v. Avedon*, 858 P.2d 598 (Cal. 1993).

²³²*Arato*, 11 Cal. Rptr.2d at 182.

C. Supreme Court of California's Discussion

"The Supreme Court reviewed the ruling of a divided Court of Appeals that, in recommending chemotherapy and radiation to a patient suffering from a virulent form of cancer, the treating physicians breached their duty to obtain the patient's informed consent by failing to disclose his statistical life expectancy."²³³ The Supreme Court held that due to the variations among doctor-patient interactions and the intimacy of the relationship itself, it was unwise to require as a matter of law that certain types of information be disclosed.²³⁴ The court refused to ratify the mandatory disclosure of life expectancy probabilities.²³⁵ The court suggested that the better rule was to instruct the jury that a physician is under a legal duty to disclose to the patient all material information.²³⁶ The court refused to require the disclosure of information that may or may not be indicated in a given context.²³⁷ Rather, they chose to leave the ultimate judgment regarding the factual adequacy of a challenged disclosure to the jury operating under the appropriate legal instructions.²³⁸

The Supreme Court determined that the evidence more than sufficiently supported the jury's decision that the doctors reasonably disclosed information material to Mr. Arato's decision regarding whether or not to proceed with the proposed treatments.²³⁹ For these reasons, the Supreme Court reversed the judgment of the Court of Appeals and remanded with directions to affirm the judgment of the trial court.²⁴⁰

An analysis of the Arato's situation is instructive. Although there was testimony that the Aratos were informed that cancer of the pancreas is usually fatal, this is not sufficient. There are many different types of cancer, and the lethality of each varies dramatically. Therefore, simply telling the patient that his cancer is incurable, without providing some general information concerning the virulence of the specific cancer at issue, is completely without meaning, according to this Court.

²³³*Arato*, 858 P.2d 598.

²³⁴*Id.* at 606.

²³⁵*Id.* at 607. The court stated that without exception, every expert witness confirmed that "statistical morbidity values derived from the experience of population groups are inherently unreliable and offer little assurance regarding the fate of the individual patient." *Id.*

²³⁶858 P.2d at 607.

²³⁷*Id.*

²³⁸*Id.*

²³⁹*Id.* at 611.

²⁴⁰*Id.*

V. PROPOSITION: FULL DISCLOSURE TO THE PATIENT SHOULD BE REQUIRED,
EXCEPT IN THE RAREST OF CASES, BUT SHOULD BE DISCLOSED
IN THE MOST SENSITIVE WAY AND FOLLOWED-UP WITH
SUPPORTIVE CARE AND THERAPY

The therapeutic privilege should be strictly construed and exercised only in the rarest cases in which the patient has expressed self-destructive intentions. The physician's obligation is to present medical facts accurately and to make recommendations to the patient which are in line with good medical practice.²⁴¹ By withholding information, the doctor is not painting an accurate picture of the patient's situation. It is not always clear that being emotionally upset necessarily inhibits one's ability to participate in rational decision-making.²⁴² Physicians have the difficult and sometimes painful obligation to participate in and encourage the education of their patients, and this often involves truth-telling.²⁴³

There is increasing evidence that open and trustworthy communication between the doctor and patient adds significantly to the dying patient's quality of life and sense of well-being.²⁴⁴ Some researchers have discovered that some of the most satisfied patients in a cancer care program were those who said they had been given the most accurate information about their diagnosis and treatment.²⁴⁵ Conversely, patients who reported receiving little or no information were the least satisfied.²⁴⁶ A study conducted by Louis Harris and Associates, for the President's Commission in 1982, confirms that doctors are becoming much more open to the disclosure of information, including "bad news," than they were twenty years ago.²⁴⁷ However, this increase in the number of disclosures may raise new problems such as the problem of blunt and insensitive disclosures.²⁴⁸

²⁴¹See Slive, *supra* note 24, at 815.

²⁴²See Meisel, *supra* note 14, at 466-467.

²⁴³See Sheldon, *supra* note 127, at 169.

²⁴⁴See High, *supra* note 2, at 6.

²⁴⁵Cori Vanchieri, *Satisfaction Highest Among Patients Told the Truth*, 85 J. NAT'L CANCER INST. 1280 (1993).

²⁴⁶*Id.*

²⁴⁷See High, *supra* note 2, at 7.

²⁴⁸*Id.* In order to avoid a disturbance to the patient, while at the same time giving the patient the opportunity to gain information regarding her illness, the physician might preface his discussion with the following:

There is some information about your treatment that you may wish to know, and I will tell you about it if you like. There's a chance that this information may upset you, and if you'd rather that I not go into details, please say so. And if you'd like, I'll discuss it with your spouse [or other family member] instead.

See Meisel, *supra* note 14, at 468.

For these reasons, a team approach would be beneficial to the patient. When a patient does receive distressing news, a team approach including such professionals as social workers and psychologists, would be most helpful in the patient's adjustment. A dying patient needs someone to listen and understand how he feels.²⁴⁹ Professionals need to be sensitive to the authority and power they possess and listen to patients who are terminally ill.²⁵⁰

It is a commonly held assumption that telling patients they are terminally ill invariably destroys "hope" and causes psychological and clinical harm.²⁵¹ Such an assumption is misguided.²⁵² Hope is a powerful tool that is not often given enough credit.²⁵³

A. The Pressure on Others When Information is Withheld from the Patient

Nondisclosure to a patient effects more than just the patient. It effects everyone involved in that patient's care, including family members and other professionals such as nurses.²⁵⁴ The diagnosis of a terminal illness, and the "tippy-toeing" around a dying patient that accompanies it, are sources of isolation and loneliness for the patient and others.²⁵⁵

When the responsible physician persists in efforts to conceal the truth from a patient, consulting physicians, nurses and social workers involved may feel as though they cannot fully discharge their duties until the patient has been told the truth.²⁵⁶ For example, if a family has not allowed disclosure to the patient, and the doctor has honored that request, the patient may be denied adequate comfort measures.²⁵⁷ The person who will suffer in such a situation is the patient.²⁵⁸

²⁴⁹See High, *supra* note 2, at 8.

²⁵⁰*Id.* at 9.

²⁵¹*Id.* at 7.

²⁵²*Id.*

²⁵³*Id.*

²⁵⁴Nurses may witness and hear their patient's deepest anxieties, fears, and personal secrets. See High, *supra* note 2, at 8.

²⁵⁵*Id.* at 8.

²⁵⁶See Freedman, *supra* note 6, at 572.

²⁵⁷For instance, one example used in a recent article was "You can't give my mother morphine or she'll know her condition is grave." *Id.* at 573.

²⁵⁸With older children and adolescents, discomfort is most often allayed by acquainting the patient as fully as possible with his condition, what will happen to him, and how he can become actively involved in his own case. BASIC HANDBOOK OF CHILD PSYCHIATRY: THERAPEUTIC INTERVENTIONS 368 (Saul I. Harrison ed. 1979). Nondisclosure, even if justified, cannot be carried out without a significant alteration in the normal patterns of team communication. See Sigman, *supra* note 135, at 766. Such a conspiracy may have an effect on collective care givers that negatively impacts on morale and care provision. *Id.*

B. Nondisclosure's Harm to the Patient

While the disclosure of a terminal illness will weigh heavily on the patient's mind, the patient could receive certain treatments which would make his day-to-day quality of life more pleasant. Obviously, with a terminal illness, the patient will die. The true question is how he will spend his remaining days—making plans, saying good-bye and being as comfortable as possible; or being kept in the dark and, most commonly, in pain. In such cases, great injury is added to the insult of withholding the truth from the patient. The "dignity of the patient . . . and the opportunity to arrange one's affairs dictate that the patient should be told of his condition."²⁵⁹ The potential harm that accompanies the withholding of information from a terminally ill patient requires that the patient be dealt with honestly and openly, as they deserve.

C. Mind/Body Medicine and its Effect on Terminal Illness

Evidence is mounting that mind/body techniques may not only improve one's quality of life, particularly for someone facing a serious illness, but actually affect the course of the disease itself.²⁶⁰ "Mind/Body Medicine" is an approach that sees the mind—our thoughts and emotions—as having a central impact on the body's health.²⁶¹

One basic tenet of mind/body medicine is that it is best to treat the whole person.²⁶² Another tenet suggests that people can be active participants in their own health care and may be able to prevent disease or shorten its course by taking steps to manage their own psychological states.²⁶³ Evidence is growing which shows that an individual's state of mind can effect physical health.²⁶⁴ Mind/Body approaches can help reduce the severity and frequency of some medical symptoms.²⁶⁵

It is quite likely that mind/body approaches can greatly improve the quality of life for patients with terminal illnesses such as cancer.²⁶⁶ Relaxation methods, hypnosis, psychotherapy and support groups have contributed to helping cancer patients deal effectively with their fears and anxieties about

²⁵⁹See Notes, *supra* note 5 at 1658.

²⁶⁰MIND BODY MEDICINE: HOW TO USE YOUR MIND FOR BETTER HEALTH 4 (Daniel Goleman & Joel Gurin eds., 1993) [hereinafter MIND BODY MEDICINE].

²⁶¹*Id.* at 5.

²⁶²*Id.*

²⁶³*Id.*

²⁶⁴See MIND BODY MEDICINE, *supra* note 260.

²⁶⁵*Id.* For instance, mind/body medicine can make chronic headaches less frequent, reduce the nausea that accompanies chemotherapy, or help speed recovery from a surgical procedure. *Id.*

²⁶⁶*Id.* at 15.

their disease and the horrific treatments they must take.²⁶⁷ Although these treatment methods will not necessarily extend the life of the cancer patient,²⁶⁸ they have shown great potential for improving the quality of life and decreasing the pain and symptoms for people with various chronic diseases.²⁶⁹ The physical and emotional risks of such treatments are minimal, while potential benefits are high.²⁷⁰ There is still great debate over the extent to which the mind can influence the body, but experience has confirmed the observation that what goes on in the mind of a patient is at least as important as what goes on inside the body.²⁷¹

Unfortunately, if a patient is not given any information about his disease, many of these options would be closed to the patient. A patient cannot benefit from a cancer support group if he does not attend the meetings. And a patient obviously will not be attending any meetings if he is unaware of the fact that he does indeed have cancer. If a patient is dealt with without reserve, the above options can be most helpful in the treatment of his or her terminal illness and the patient's state of mind can be an integral part of the strive for comfort.

D. Group Decision-making in Regards to Disclosures and Services Rendered to the Patient

When investigating the possibility of cancer, a physician must be aware of the patient's emotional state.²⁷² If the physician is unsure about the patient's ability to handle the diagnosis, involving the family and consulting a psychiatrist may be in order.²⁷³ By sharing the responsibility of deciding whether or not to make a full disclosure, the doctor can use the input of other professionals in weighing the risk and benefit ratio of truth-telling.

Some commentators have suggested that it would be "appropriate to provide a regular forum for more input and dialogue in individual situations and to allow the responsibilities of such judgments to be shared."²⁷⁴ One such forum might be an "Ethics Committee" comprised of doctors, social workers, attorneys and theologians.²⁷⁵ Such committees would review individual situations of ethical dilemma and provide assistance and safeguards for both

²⁶⁷See MIND BODY MEDICINE, *supra* note 260, at 15.

²⁶⁸Mind/Body treatments should not be used in place of conventional treatments for diseases. They should be part of a well-rounded overall treatment program. See MIND BODY MEDICINE, *supra* note 260, at 18.

²⁶⁹*Id.* at 17.

²⁷⁰*Id.*

²⁷¹*Id.* at 21.

²⁷²See Boverman, *supra* note 100, at 1307.

²⁷³*Id.*

²⁷⁴See Teel, *supra* note 157, at 8.

²⁷⁵*Id.* at 9.

the patients and their medical caregivers.²⁷⁶ Such advisory committees diffuse the responsibility for making certain moral or ethical judgments and encourage a full discovery of all options available to a particular patient.²⁷⁷

However, there are certain disadvantages to the group decision-making process. The first problem is time. Obviously, the more people involved in a decision, the longer it takes to reach a decision. Also, the committee might experience some opposition from doctors and the families of the various patients under discussion. Some believe the involvement of such a group is an imposition on their independent judgment. However, these committees usually serve in strictly an advisory capacity. Therefore, doctors should not feel threatened and should take advantage of their input, for the patient's sake.

VI. CONCLUSION

Since "the physician-patient relationship involves an element of trust and confidence," "obligations of good faith require the [doctor] to make the fullest possible disclosure concerning risks of any proposed action which may result in injury to the patient."²⁷⁸ When offering truth, doctors must recognize that the patient's choices should be respected not because they agree with the patient's choices, but simply because those are the patient's choices.²⁷⁹

The very foundation of the doctrine [of informed consent] is every man's right to forego treatment or even cure if it entails what for him are intolerable consequences or risks, however warped or perverted his sense of values may be in the eyes of the medical profession, or even of the community, so long as any distortion falls short of what the law regards as incompetency.²⁸⁰

"Only the patient sufficiently knows his . . . capacity for pain and suffering, future business and social plans, and religious beliefs to [best] evaluate . . . a particular treatment" and the risks which accompany it.²⁸¹

A decision to withhold information from a terminally ill patient fails to consider the interests of the patient and his family in receiving information so they might prepare for the future. Of course, the patient will react negatively to the word "cancer." But the patient still ought to be told as much as possible regarding the nature of his cancer, and the nature of the operation and/or treatments to be received.²⁸² Most doctors are accustomed to telling patients

²⁷⁶*Id.*

²⁷⁷*Id.*

²⁷⁸See Smith, *supra* note 86, at 350.

²⁷⁹See Freedman, *supra* note 6, at 573.

²⁸⁰2 F. HARPER & F. JAMES, THE LAW OF TORTS 61 (2d ed. Supp. 1968)

²⁸¹Notes, *supra* note 5, at 1646.

²⁸²One strong supporter of truth telling went so far as to say that "a claim that a patient cannot bear to be told the truth is an insult to the patient. . . . even persons who are

they have cancer and know how to handle the varied patient reactions to such news.²⁸³

It has repeatedly been asserted that the disclosure of such information as "prognosis" in a terminal illness is followed by fear and despondency which may lead the patient to suicide.²⁸⁴ In actuality, however, the incidence of depression and suicide in cancer patients and the relationship of such reactions to the disclosure of such information is not known.²⁸⁵ "There are few documented harmful effects of disclosure and [numerous] proved benefits."²⁸⁶

The therapeutic privilege is a controversial exception and the law is not entirely clear as to the extent of the privilege.²⁸⁷ The therapeutic privilege exception to the informed consent doctrine may tend to legitimate the physician's natural aversion to disclosing unpleasant information to a patient. It should, therefore, be strictly circumscribed in its scope so as to avoid swallowing the general obligation of disclosure.

The disclosure of prognosis information, including life expectancy estimates, should be included when making a full disclosure. Doctors tend to give less and more vague information about prognosis, citing its uncertainty and lesser relevance to future actions as their reasons.²⁸⁸ Although this type of prediction is obviously an inexact science, it is still valuable to the particular patient in his or her decision-making. It is virtually impossible for a doctor to tell a patient "you have X weeks left." A general range or some particular case examples, however, would serve the purpose well. This is particularly true when, such as in the case of *Arato v. Avedon*,²⁸⁹ the patient specifically requests to be told when their illness becomes terminal or incurable. The therapeutic privilege should never be employed to override a competent patient's expressed wishes.²⁹⁰ As one doctor remarked, "[b]y explaining diagnosis, prognosis, and treatment options to the patient, I was creating the basis for freedom: . . . freedom to make

suffering from severe impairments, physical and mental, have the ability to make choices that effect their destiny." David Morris, *Truth-Telling in Medicine*, 247 JAMA 2659 (1982) (Letters Section).

²⁸³See Freedman, *supra* note 6, at 573.

²⁸⁴See Oken, *supra* note 3, at 1125.

²⁸⁵*Id.* at 1126.

²⁸⁶See Novack, *supra* note 142, at 2984. Such benefits include improved quality of life and time for preparation of business affairs. See *supra* note 251 and accompanying text.

²⁸⁷See Botkin, *supra* note 49, at 900.

²⁸⁸N. T. Miyaji, *The Power of Compassion: Truth-Telling Among American Doctors in the Care of Dying Patients*, 36 SOC. SCI. MED. 249 (1993).

²⁸⁹11 Cal. Rptr. 2d 169 (1992).

²⁹⁰See Botkin, *supra* note 49, at 900.

informed choices."²⁹¹ Including prognosis in a timely disclosure, allows the patient and his family time to prepare themselves emotionally and accept the impending death.²⁹² The alternatives in a situation of terminal illness are not living or dying—death is inevitable. But there are some things worse than dying, such as dying in silence²⁹³ because you were never given the opportunity to talk about your life, illness, and pending death. By withholding information about a terminal illness, the patient's right to self-determination is compromised unnecessarily.

The principle behind the informed consent doctrine is that patients should be able to participate in decision-making concerning their health. Patient participation is an integral part of the doctor-patient relationship. To safeguard the autonomy and interests of both the patient and the physician, decision-making in medicine must become a joint undertaking.

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²⁹¹Antonella Surbone, *Truth Telling to the Patient*, 268 JAMA 1661 (1992) (Letters Section).

²⁹²See Annas, *supra* note 26, at 62.

²⁹³See Freedman, *supra* note 6, at 574.